

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

19469

Registrar's No.

7

ED MAY 20 1948
Registration District No. 521

Primary Registration District No. 6082

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Arrow Rock Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Arrow Rock Twp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 49 years years, months or days

3. (a) PRINT FULL NAME MARY C. EILERS

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color W. 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Herman H. Eilers 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct. 3 1862 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 6 4 hr. min.

9. Birthplace St Charles Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

12. Name H. H. Bierbaum 13. Birthplace Germany (City, town, or county) (State or foreign country)

14. Maiden name Henriette Brune 15. Birthplace Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Hugo Eilers (b) Address Nelson Mo.

17. (a) Burial (b) Date thereof Apr 9-1948 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arrow Rock Mo.

18. (a) Signature of funeral director Campbell (b) Address Marshall Mo.

19. (a) Apr 9 1948 (b) Mrs. W.E. Shackelford (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline
(c) City or town Arrow Rock Rural (If outside city or town limits, write "RURAL")
(d) Street No. Arrow Rock Twp (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7 year 1943 hour 11 minute 45 P.M.

21. I hereby certify that I attended the deceased from April 7 1943 to April 7 1943
that I last saw her alive on April 7 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic
tuberculous pulmonary
tuberculosis Duration 15 yrs

Due to _____
Due to _____

Other conditions Chr. high cardiac (Include pregnancy within 3 months of death) 8 yrs

Major findings: Of operations 13 f. 1
Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) While at work _____ (e) Means of injury fall

3. Signature W. R. Marshall (M. D. or other) _____
Address Marshall Mo. Date signed 4/8/43

5-15-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed

John H. Penick

Licensed Embalmer No. 1171

P. O. Address Marshall Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.